HIPAA DISCLOSURE AUTHORIZATION FORM

Full Name		
I hereby authorize	(Discloser)	to use or disclose my
	(Discloser)	
protected health information	ation related to	
		(Type of Information)
to		for the following purpose:
	(Recipient)	
 I understand that receives this authorization I understand that be effective as to where other act understand that I refuse to sign to the subject to rediscontinuous authorization. 	nt, at any time, this author horization receives a writte of the disclosure of recordstion has been taken in remy health care and the pay his form.	the protected health information described by rization may be revoked, when the office that en revocation, although that revocation will not whose release I have previously authorized, or liance on an authorization I have signed. I rement for my health care will not be affected if elosed, pursuant to this authorization, could be d, if so, may not be subject to federal or state
Date	Signatu	are of Individual or Representative
	Authority or Re	elationship to Individual, if Representative
	This authorization will exp	pire on Il be six years from the date of this
authorization	icu, me expiration date wil	1 oc six years from the date of this

COPY PROVIDED: The subject of this authorization shall receive a copy of this authorization, when signed.